



# KANSAS

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DIVISION OF HEALTH POLICY AND FINANCE

ROBERT M. DAY, DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

**Testimony on:**  
Medicare Part D and Dual Eligibles

**presented to:**  
House Committee on Appropriations

**by:**  
Scott Brunner  
Division of Health Policy and Finance

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**For additional information contact:**

Luke Thompson  
Division of Health Policy and Finance

Landon State Office Building  
900 SW Jackson Street, Suite 900  
Topeka, KS 66612  
Phone: 785-296-3981  
Fax: 785-296-4813

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**Medicare Part D and Dual Eligibles**

Mr. Chairman and members of the committee, my name is Scott Brunner and I am the State Medicaid Director with the Division of Health Policy and Finance (DHPF). I am providing testimony on the transition of Medicaid beneficiaries into the Medicare prescription drug benefit.

**The Medicare Modernization Act**

The Medicare Modernization Act of 2003 (MMA) made a prescription drug benefit available to every Medicare beneficiary beginning on January 1, 2006. This benefit, known as Medicare Part D, also pays for prescription drugs for low-income seniors and persons with disabilities who are eligible for both Medicare and Medicaid. These individuals are referred to as dual eligibles and there are approximately 40,000 dual eligibles enrolled in Kansas Medicaid. Before Medicare Part D, the Kansas Medicaid program paid for prescription drugs for these beneficiaries.

The federal government created regions across the country and contracted with private insurers to provide prescription-drug coverage to Medicare beneficiaries, either through a drug-only plan or a comprehensive health plan (i.e., prescription drugs and regular medical care).

On January 1, 2006, Kansas blocked dual eligibles from receiving Medicaid coverage for any prescription drugs covered by Medicare Part D. They had to choose a Part D plan or lose prescription drug coverage. There have been concerns about which drugs Part D plans will cover and whether dual eligibles will be able to receive the specific drugs they need. This population is often sicker and in need of more medications than the rest of either the Medicare or Medicaid populations. Part D plans are required to cover at least two drugs in every therapeutic class and must provide all or substantially all drugs in specific classes, but the plans have flexibility in the determination of drug classes and they can establish closed formularies.

The Center for Medicare and Medicaid Services (CMS) reviewed the formularies developed by the Part D plans and contracted with the U.S. Pharmacopoeia Convention to develop model guidelines for classifying drugs and drug categories. However, dual eligibles with HIV/AIDS, epilepsy, or mental illness may be vulnerable if Part D plans cover only a limited number of newer, more effective drugs. States have the option to cover specific drugs that are not covered by Part D plans, but no federal match will be available.

CMS automatically enrolled dual eligibles in Part D plans in November. Dual eligibles were randomly assigned to Part D plans that met benchmark benefit and cost levels. These auto-

assignments were shared with the states in November through an electronic file exchange. Kansas Medicaid was able to validate that dual eligibles were enrolled in a plan; however we were not able to check that the auto-assigned plan was the best fit for each beneficiary. Dual eligibles were allowed to change plans before December 31, 2005 and can change plans each month. Other Medicare beneficiaries have until May 15, 2006 to enroll in a Part D plan to avoid a financial penalty in their cost sharing. Companies began marketing their Part D plans on October 1 of last year.

Other low-income people (with incomes up to 150.0 percent of the Federal Poverty Level (FPL)) are potentially eligible for assistance with premiums and co-payments. Others, who have higher income and asset levels, and who have greater than \$2,250, but less than \$5,100, in total annual drug costs will have a gap in coverage. This gap is commonly referred to as the “doughnut hole.” CMS has issued guidance to states on how to treat the costs Medicare beneficiaries will have in this doughnut hole. Some people may become eligible for Medicaid through the medically needy population category, which allows people to spend down their resources on medical services to achieve income eligibility. We do not anticipate significant increases in the medically needy population, if CMS does allow this out-of-pocket spending for drug costs in the doughnut hole. More likely, we will see a reduction in the number of medically needy who use their monthly drug costs to achieve their spenddown and be eligible for Medicaid.

## **Preparing for the Transition to Part D**

State agencies have been working for almost two years to prepare for the implementation of Medicare Part D. I led an interagency workgroup, made up of senior program directors within the Department of Social and Rehabilitation Services (SRS), the Department on Aging, the Kansas Department of Health and Environment, the Kansas Insurance Department, and the Division of Health Policy and Finance. The group's charge was to coordinate the activities of state agencies to identify all populations affected by Part D, to make consistent policy decisions across agencies, and to identify resources in each agency that could be used for outreach activities. The group also was used to share information coming from CMS and the Social Security Administration.

An early decision of this group was to divide responsibilities for the populations affected by Part D. The Department on Aging was primarily responsible for conducting general outreach to Medicare eligible beneficiaries and specific insurance counselling through the Senior Health Insurance Counselling Program of Kansas (SHICK). DHPF and SRS were responsible for notification and outreach for Medicare and Medicaid dual eligibles and preparing to receive applications for the Low Income Subsidy. The Department of Health and Environment and the Insurance Department had a role in providing information to individuals and community organizations through existing publications, call centers, and networks. Other specific workteams were established for issues such as training and publications, which involved staff from each agency.

Within DHPF and SRS, transitioning the duals involved mailing notices to beneficiaries to raise awareness of Part D and the impact on Medicaid benefits. CMS provided a schedule of mailings for the dual eligibles and all Medicare beneficiaries soon after the final regulations were

complete last January. DHPF planned additional notices that would match and hopefully explain what was in the CMS letters to reduce confusion among Medicaid beneficiaries. The hope was to raise awareness of the change in benefit without creating panic. These notices were sent to beneficiaries and their responsible parties if a family member or guardian helped make decisions.

At the same time, SRS developed training for regional office staff on Medicare Part D. The first round of training provided an overview of Medicare and how the new benefit was structured to interact with Medicaid. Since most of the policy details had not been developed when this training was developed, it was used to raise awareness of the coming changes. A second round of training occurred during November and December after the detailed transition policy was developed and changes in the eligibility system were completed. Current training efforts are focusing on working with eligibility staff to help beneficiaries use the Part D plan finder tool to evaluate the costs and formulary offerings of different plans.

## **Transition Issues for Dual Eligibles**

Auto enrollment created the first issue for Medicaid. The initial auto enrollment process occurred in October 2005 for all full benefit dual eligibles beneficiaries enrolled from April 1, 2005 through October 15, 2005. A monthly auto enrollment process will occur thereafter to ensure prescription drug coverage is available for new Medicaid beneficiaries. All individuals identified as a full dual eligible since May 2005 were automatically enrolled into a Medicare prescription drug plan. In Kansas, about 38,000 people were auto enrolled. This includes individuals who received Medicaid during this time period, but are no longer eligible. CMS specifically designed the process to include a broad group of individuals, and some ineligible individuals were included in the auto enrollment process. All dual eligibles were deemed eligible for the Low Income Subsidy and that eligibility lasts until December 2006.

CMS auto enrolled individuals by their current Medicare address. This could be different than the address reflected in the Medicaid file. If both files indicated a Kansas address, there was little impact on the process of auto enrollment. However, persons who lived in another state, or who recently moved to Kansas from another state, may be auto enrolled into an out of state plan. This occurred in approximately 250 cases, and another 1,000 beneficiaries were enrolled in a plan that operates in Kansas but with that plan in another state. CMS provided lists of the auto enrollment results that were shared with SRS caseworkers, Home and Community Based Service waiver case managers, and state institution reimbursement officers. This information was provided to help case workers and case managers assist beneficiaries that had questions about auto enrollment or assist in clarifying the impact of Part D on their Medicaid benefit.

DHPF and SRS issued specific guidance to eligibility staff to ensure that questions about the impact of Part D on Medicaid beneficiaries would be answered without referring the question to SHICK or another agency. Eligibility determination staff were not supposed to provide direct assistance on choosing among Part D plans. Instead, questions about plan choice and coverage decisions were referred to Medicare, Community Mental Health Center and Community Developmental Disability Organization case managers, the individual's pharmacist or medical provider, Working Health Benefit Specialists, or specific staff designated by each Regional Office.

DHPF and SRS are continuing to work with beneficiaries to trouble shoot issues with enrollment. We are receiving calls from community partners and CMS to work on specific eligibility cases and resolve them through CMS and the Part D plans.

## **Emergency Actions after January 1, 2006**

As the Part D benefit started, we received many calls from pharmacists about difficulties in identifying dual eligibles in Medicare system. CMS created a central electronic point of sale system that contained all Part D enrollees, their plan assignment, and benefit coverage for each plan. This system was not responsive or correct for much of the first week of Part D. There were a variety of issues including not being able to find beneficiaries in the system, confusion over which Part D plan dual eligibles were enrolled in, and incorrect cost sharing amounts. To make matters worse, pharmacists were unable to contact the Part D plans through customer service lines and the emergency mechanisms CMS had put in place to ensure that beneficiaries would not leave the pharmacy without needed medications was unable to handle the volume of requests.

Governor Sebelius directed DHPF to take emergency action to ensure that dual eligible beneficiaries would not leave a pharmacy without medically necessary prescription drugs. On January 13, we turned off the block in the Medicaid Management Information System that prevented pharmacy payments for Medicare eligible beneficiaries. We provided direction to pharmacies that Medicaid could be billed for prescription drugs for Medicaid eligible beneficiaries if the Part D eligibility information in the point of sale system was incorrect or unavailable, if the cost sharing amounts that were indicated were incorrect, or if the temporary mechanism for payment created by CMS failed. The Medicaid payment was not intended to supplement a Medicare payment. As of January 30, 37,470 prescriptions have been paid for by Kansas Medicaid for 11,732 individual beneficiaries. We have expended \$2.66 million. Below is a detailed table of expenditures and prescriptions filled by date.

This temporary measure was only offered until February 1, 2006. We will be evaluating this decision next week to determine if it should be extended. We were also notified last week that CMS is working on a mechanism to provide full federal reimbursement for costs incurred by states providing transitional coverage for dual eligibles. There are 26 states that have taken similar actions to protect dual eligible beneficiaries.

<b>Date</b>	<b>Unique Beneficiaries</b>	<b>Claims</b>	<b>Paid Amount</b>
01/13/2006	662	1237	\$82,901.76
01/14/2006	713	1600	\$99,268.90
01/15/2006	199	437	\$28,356.62
01/16/2006	1687	3551	\$250,953.37
01/17/2006	1505	3243	\$241,569.91
01/18/2006	1395	2847	\$215,630.33
01/19/2006	1364	2622	\$188,021.58
01/20/2006	1226	2457	\$170,081.29
01/21/2006	534	1032	\$74,582.17
01/22/2006	166	315	\$25,634.32
01/23/2006	1571	3329	\$239,692.64
01/24/2006	1281	2538	\$191,491.64
01/25/2006	1231	2538	\$167,132.82
01/26/2006	1184	2469	\$183,507.88
01/27/2006	1262	2702	\$188,763.26
01/28/2006	516	1024	\$66,609.64
01/29/2006	239	546	\$32,738.90
01/30/2006	1525	2983	\$212,957.50
<b>Total</b>		<b>37470</b>	<b>\$2,659,894.53</b>

## Future Part D Activities

Governor Sebelius has asked DHPF to begin planning on a method to provide copayment assistance for dual eligibles. Under Part D, full benefit dual eligibles are charged a \$1 or \$3 co payment per prescription. For some dual eligibles, especially individuals on the Home and Community Based Service Waiver programs, Medicaid did not charge a copayment for prescriptions. We are developing a mechanism to pay these costs for dual eligibles that were not subject to copays before Part D and gathering information on the number of people that could be affected and the total costs.

Another impact that has not been assessed is the ability of beneficiaries to get the prescription drugs they need through the Part D plans. The plans are required to cover two drugs in each therapeutic class, but evaluating whether each plan covers the drugs that auto assigned beneficiaries' need has to be done on a case by case basis. The plans were required to provide a transitional supply of the medications each beneficiary was taking for the first 30 days of the Part D benefit. After that supply runs out, beneficiaries will have to determine if their plan covers that drug, if a therapeutic substitution to a formulary drug is appropriate, or if they need to work with their physician to change prescriptions. Each plan also has an exception process to appeal coverage decisions, but these have not been evaluated. Medicaid covered most, if not all, prescription drugs for dual eligibles prior to January 1. The next round of Part D impacts will surface for beneficiaries that were on established drug regimens that will not be sustained by the Part D plan formularies.

That concludes my testimony. I am happy to stand for questions.